NHS

NHS Innovations South East

Report of Proceedings Child Protection Forum

Charing Cross Hotel, London. 22nd January 2010

Background

The Child Protection Forum was held in January 2010 at London's Charing Cross Hotel. The event brought together leading practitioners from all the disciplines and agencies concerned with child protection and, in particular, child sexual abuse. The Forum was convened by NHS Innovations South-East (NISE), one of nine regional NHS Innovations organizations in England, whose dual mission is to promote a culture of innovation within NHS organizations in their region and to provide expert advice and support (technical, commercial, financial and legal) to NHS innovators and inventors, to help them realize and commercialize their ideas. The idea for this Forum grew out of NISE's plans to disseminate news of an important new development in the field of child protection; the Oxford Child Sexual Abuse Examination Skills Trainer (sometimes referred-to simply as the Child Protection Training Aid).

Child Sexual Abuse is a highly emotive topic. It is also an issue that requires a holistic, multi-agency response. The medical practitioners responsible for the development of the Child Protection Training Aid believe it offers the prospect of more accurate and better-evidenced diagnoses of child sexual abuse. However they – and NISE - were understandably cautious about making such claims publicly and were more concerned to share details of their work, in confidence, with others involved in the field of child sexual abuse. It was therefore decided that NISE should organize an invitation-only event at which medical and nursing staff, police officers, social workers and lawyers working in that field could see and be briefed on the new Training Aid and consulted about its implications, if any, for their work.

As the event began to take shape, it quickly became clear to the organizers that this was an opportunity to take soundings from its multi-disciplinary expert audience, not only about the Child Protection Training Aid but also about the broader innovations agenda within the NHS and the other ways in which it might be brought to bear on the problem of Child Abuse. The result was an extremely well-informed, wide-ranging and highly-participative programme that produced a number of valuable insights, as this Report of Proceedings hopefully demonstrates.

Introduction to the Forum

Earl Howe,

Opposition Spokesman for Health and Social Services in the House of Lords.

Earl Howe began his opening address by reminding Forum delegates that *"child protection…. is an emotive subject in the mind of the general public" and that child sexual abuse "is seen by many as repellent in a way that nothing else is…".* He wanted to make that point, Earl Howe said, *"to reinforce in all our minds that we are dealing today with a subject that carries with it a very high degree of public and political sensitivity."*

Earl Howe went on to acknowledge the pressures experienced by those investigating allegations of child abuse, and especially sexual abuse, who, he said, *"are inevitably aware that they may be sitting on a public relations tinderbox, should the case ever reach the press."* And there was, he said *"another, more immediate, pressure which they surely feel as well; and that is the imperative of reaching the right conclusion."* After all, he argued, the stakes are extraordinarily high – most obviously for the children and families involved and also for *"the reputation and standing of … the various public agencies responsible for the protection of children. It is important for those agencies to enjoy public support and credibility."*

"Sometimes", Earl Howe suggested *"that public support falters. It can also falter in cases of the opposite kind, such as those of Sally Clark…convicted of murdering her two small sons."* Noting that the jury appeared to have been greatly influenced by 'evidence' based on *"an unproven rule of thumb",* Earl Howe said Mrs Clark's conviction *"conveyed the clear message that there are circumstances when making an assumption about what has happened is as good as producing hard evidence."* Reminding delegates that the conviction was later quashed by the Court of Appeal when it transpired that *"there were perfectly plausible organic causes for the deaths of both the infants"* Earl Howe said *"I mention that case in particular because it was the case that aroused my interest in the subject of false allegations of child abuse and the failures in our system that may lead to wrong decisions being made by the authorities. This is not"* he said *"an aspect of the child protection discourse that excites much interest or sympathy…. but in order to detect and apprehend (genuine) abusers, we need to have systems of investigation in place on which we can rely.* The cases of Victoria Climbie and of Sally Clark's sons', he said, *"are two sides of the same coin. In each case the investigations were flawed; and in each case the conclusions reached rested heavily on assumption and inference rather than fact."*

Earl Howe went on to express similar concerns about child abuse allegations stemming from so-called 'recovered memory' events which, he said, could still trigger in-depth investigations, even though *"it is now well-established in the field of psychology… that the phenomenon of 'recovered memory'… is wholly lacking in scientific validity. It is"* he continued *"that absence of critical judgement – the absence of scepticism – which is the enemy of sound investigation."* There are problems too, he argued, in cases where the evidence is ambiguous, such as *"when there is a suspicion of Fabricated or Induced Illness (FII), which is the new name for Munchausen's Syndrome by Proxy."* Describing a 'typical' FII scenario and the difficulties it posed for doctors, Earl Howe praised the guidance issued by the Royal College of Paediatrics and Child Health which he described as *"a model of balance and clarity… based on principles which surely apply to any situation in which child abuse is suspected. A careful process of differential diagnosis combined with measured judgement should characterise the investigation."*

Turning next to what he described as *"perhaps the most notorious instance of where this all went wrong…. the Cleveland child abuse scandal of the late 1980's"* Earl Howe again highlighted the problems caused by paediatrician's reliance on a single test which had never been properly-validated. *"The public outcry (over Cleveland)…"* said Earl Howe *"led to an enquiry chaired by Dame Elizabeth Butler-Sloss, which looked at 121 cases where sexual abuse had been alleged. Of those cases, 96 were subsequently dismissed by the courts."* The damage was already done, however. *"Apart from the emotional trauma to the families and children involved, the Cleveland scandal…. instilled the wrong impression in the public mind; that allegations of childhood sexual abuse are often based on hype. On a more positive note it taught us that over-reliance on one diagnostic method is hugely risky. The lessons of Cleveland resonate with us twenty-odd years on; and it is why today is so important."*

Earl Howe noted that when abuse is suspected *"the difficulty for doctors of making a diagnosis is often made more acute by their having to rely heavily on photographs. This is hard, because there are several naturally occurring conditions in infancy which have signs and symptoms that are similar to those of sexual abuse and which are frequently impossible to distinguish on the basis of photographs alone. As a result practitioners are sometimes reluctant to put their necks on the block and offer a firm opinion as to whether or not a child has been abused."*

"The devices we are going to look at this morning", he said *"are designed to alleviate this difficulty. As training aids, first and foremost, their purpose is to assist in the process of differential diagnosis and to contribute to the measured and rational approach to investigation and diagnosis which I have just outlined. As such, I believe that they are tremendously welcome; and I should like to congratulate not only Dr King and Dr Paul, who designed these tools but also the team at NHS Innovations South East who have worked with Dr King and Dr Paul for the last five years to bring them to fruition."* He concluded *"I therefore think that we are in for a very enlightening morning and one which, I hope, for many of you will prove of great benefit in the difficult and hugely important work in which you are engaged."*

Earl Howe

Earl Howe has been Opposition Spokesman for Health and Social Services in the House of Lords since 1997.

After seventeen years in the banking industry, Lord Howe became a Whip in the last Conservative Government in 1991. The following year he was appointed to the Ministry of Agriculture, Fisheries and Food as Parliamentary Secretary and in 1995 he became a Parliamentary Under-Secretary of State at the Ministry of Defence.

Lord Howe is an elected hereditary peer under the House of Lords Act 1999. Amongst a number of charitable appointments, he is Chairman of RAFT (a medical research charity specialising in burns and melanoma), President of the National Society for Epilepsy and Patron of the Chiltern Society.

The Oxford CSA Assessment Training Aid

The Oxford CSA Assessment Training Aid is the brainchild of Dr Sue King, an associate specialist in community paediatrics at the Oxford Children's Hospital. Dr King developed the The Oxford CSA Assessment Training Aid in collaboration with Dr Sheila Paul, a Buckinghamshire GP and forensic physician for Thames Valley Police, and with the assistance of NHS Innovations South-East (NISE).

The The Oxford CSA Assessment Training Aid consists of an anatomical model and a DVD, which are used to train medical practitioners and other authorized specialists in carrying-out a colposcopic examination of the child's genitalia, using a magnified, illuminated view obtained by the use of a colposcope - in suspected cases of Child Sexual Abuse (CSA).

Individual medical practitioners may take some time to acquire the experience and confidence they ideally need when called upon to make an assessment of prepubertal child abuse. CSA assessment is difficult and the stakes are obviously extremely high for everyone concerned.

Because the stakes are so high and practical case-experience limited, realistic and effective training is of critical importance. Accurate assessment crucially requires a proper understanding of the wide variations that may be found in the appearance of the hymen and other genital tissues in prepubertal girls. The main reason why the The Oxford CSA Assessment Training Aid is so badly-needed is that there are variations in hymenal appearance - including congenital presentations - which can be mistakenly identified as symptoms of abuse. Though doctors may be aware of these variations, accurately and confidently distinguishing between congenital presentations and the symptoms of CSA requires specialized training. However, much current training still relies on photographic and other illustrations and / or on the use of toys, such as dolls and even teddy bears.

Dr King's idea was to develop instead a highly-realistic anatomical model, which comes with three inserts presenting three different 'conditions':

1. A prepubertal female with an annular hymen
2. A prepubertal female (congenital variation) presenting a hymenal notch,a cresentic hymen,and an intravaginal ridge.
3. Post pubertal presentation with a complete transaction of the hymen.

The model is produced under licence by a specialist manufacturer (Pharmabotics Ltd.) and is used in conjunction with a training DVD made by Dr King and Dr Paul.

Dr King and Dr Paul told the Forum they believed the The Oxford CSA Assessment Training Aid offers a range of potential benefits. Better training for medical practitioners should also mean speedier and more reliable assessment and better-articulated evidence for those involved in the prosecution and / or management of abusers.

Dr. Suzanne King

Dr King has practised as a paediatrician for 34 years and, since 1981, as a Community Paediatrician in Oxford, working regularly in the child protection arena. Her other interests include Audiology and Adoption and Fostering.

Dr King undertook her initial child sexual abuse training in Leeds and London and is now an accredited Child Protection Trainer (RCPCH). Formerly responsible for developing medical child sexual abuse services for children in Oxfordshire, working with colleagues from police and social services, she is currently jointly responsible for child protection training in the Oxford Radcliffe NHS Trust and a member of the local safeguarding board.

Dr Sheila Paul

Dr Paul is Forensic Physician for the Thames Valley and a G.P. in South Bucks. She is involved in the full range of clinical forensic medicine and attends sexual assault complainants of all ages, though she specializes in child sexual abuse. Dr Paul has written papers on this subject and is also one of the group of authors of 'The Physical Signs of Child Sexual Abuse', March 2008, RCPCH.

Involved in the development of national protocols, Dr Paul is a Fellow of the Faculty of Forensic and Legal Medicine, sits on the Standing Committee for Child Protection at the RCPCH and is the named GP for Child Protection in Buckinghamshire.

Discussion Forum

Introduction

The Discussion Forum was chaired by Dr James Morris, Medical Director of The Oxford Radcliffe Hospitals NHS Trust. Introducing the session, Dr Morris commented:

"Listening to Sue and Sheila, I was struck by how they are determined to make this training tool work. It is essential to disseminate the information so that all paediatricians, when they approach children, do with an open, prepared and informed mind, an ability to dispassionately record what they see, and an ability to communicate that information accurately and concisely."

Dr Morris was also keen to emphasize the importance of effective teamwork, observing that *"Thinking about the wider problem (of child abuse) and where the process sometimes goes wrong, it is often a matter of multiple agencies working together but not transmitting information properly. Teamwork is critical. Things go wrong where teams have never been built up, or have fractured, and so lack the effective relationships that good teamwork brings."*

Finally, Dr Morris described the CSA Examination Skills Trainer as *"an excellent example of the way innovation from within the NHS can deliver improvements in practice, better outcomes for service-users and a better quality of service generally."* It made him wonder, he said, what other aspects of our joint efforts to protect children who have been, or are at risk of being abused we should be looking to improve. But perhaps that question was too narrow. *"Perhaps we should examine how as a society we identify, assess and manage the problem. There is often no easy answer, but it is critical to get it right. "*

Identification of child sexual abuse

Dr. Morris's remarks prompted a lively discussion, initially about possible ways of improving the identification of sexual abuse. Several delegates were concerned about the contradictory pressures faced by 'front-line' workers. As Dr Fawzia Rahman, a Consultant Paediatrician from Derby, representing the BMA observed, *"paediatricians and social workers often find themselves in a no-win situation. They are demonised if they raise the issue of possible abuse and demonised if they do not".*

On a similar note, Dr Kim Holt, of the BMA felt that *"When tragedies happen, we should get away from blaming front line people and look at the whole system. Some parts of the country are working well, and some have excellent practice; in others it has clearly failed. Are problems due to local services available resources, or to the culture in those particular agencies? What is needed is support from those agencies for people to undertake training and attend meetings. Managers need to understand safeguarding and take responsibility for making sure those areas work."*

Dr Deborah Hodes, a paediatrician working with a Sexual Abuse Referral Centre in London, was the first of a number of speakers who emphasised the importance of listening to the child, prompting Dr Eleni Stathopulu, a paediatrician from the Medway NHS Foundation Trust, to add that "*in the majority of sexual*

abuse cases in young children, there are no physical signs (of abuse). We have therefore to get better at listening to children and placing what they say 'on the formal record".

Dr Morris asked delegates whether, in their experience, many children present to an agency directly, complaining of sexual abuse? Nigel King, from BASPCAN, a former police officer, said that, in his experience, *"most abuse cases came from children speaking to a third party. The problem, however, is that often when children report being sexually assaulted, the last incident was weeks or even months previously, so the chance of finding something forensic is very small. "*

Dr Jacqui Mok, from the Royal Hospital for Sick Children in Edinburgh, observed that *"you have to train people to listen to children. In Edinburgh, our interagency Child Protection Procedures state that interagency referral discussions (strategy discussions) must take place between 3 key agencies – Police, Social Work and Health. We then make a decision on whether and how to proceed with an investigation. It is important to remember that it is not just about forensic evidence but the welfare of the child."* She continued "*Training is also important to help people be aware of and respond to children; 25% of referrals come from school teachers, because children tell them what has happened to them. Teachers can be trained on how to react but it is not their job to do investigative interviews."*

Dr James Morris asked whom teachers would tell if a child reported abuse. Dr Mok said the obvious choices were the police, a social worker or paediatrician. In her experience, *"teachers like phoning a doctor, as it makes their life easier, but you need a system for staff to feed into".*

Agency and Inter-agency considerations

Some delegates felt that there should be a child protection service in schools, though it was not clear what this would look like or who would manage it. Others pointed out that the introduction of the Common Assessment Framework meant that every school should now have clear information-sharing protocols and referral procedures in place should a child report or show signs of having been abused. This did not, however, obviate the need for training.

Dr Vicky Evans, a paediatrician with the SARC in Manchester pointed to the potential confusion that can arise from the fact that, once abuse is reported, there are effectively two processes running 'side by side'. *"One is concerned with the welfare of the child and the other with the criminal or civil justice process. We often focus on one or the other, and it is difficult for people to be objective enough to see that the case may need treating differently."* Dr Aideen Naughton, from the Children's Centre at Nevill Hall Hospital in Abergavenny, had similar concerns, commenting that *"We need to take each case on its merits, bearing in mind the criminal justice and welfare considerations. Perhaps sometimes the momentum of a process drives cases too far to one side or another."* Dr Naughton also felt it was *"crucial that we get all doctors within a clinical governance framework that is run within the NHS, rather than being outsourced (or) we will continue to have difficulty with the LSCBs…. The long-term outcome for children is a health outcome, which is an NHS responsibility."*

Noting that *"Lord Bradley's review concerning the provision of forensic medical services recommended exploring the transfer of healthcare from the Home Office to Health"* Professor Ian Wall, President of the Faculty of Forensic & Legal Medicine at the Royal College of Physicians commented that *"While we have no problem supporting this as a concept, there might be issues if, on being transferred to PCTs, work is immediately outsourced to another private provider without proper standards being built in."*

Dr Richard Lloyd, Forensic Medical Examiner, Thames Valley Police, agreed saying "*The prison medical service was disbanded and handed to the PCTs. While the prison medical service may not have been very good, it did have some good points. PCTs outsource everything, and the prison medical provision is now a mess. We need to be quite careful before thinking that the NHS taking over services will make them wonderful."*

Dr Evans also felt there was *"a problem of social care services and police making decisions based on little information and little training."* She continued *"there have been cases where the police are not referring children for STD treatment because there is no discharge, which is nonsense. Perhaps because different agencies have a different agenda, they use information in different ways."*

Several contributors from the floor made reference to strategy meetings. Though the general consensus was that (multi-agency) strategy meetings were 'a good thing', some delegates had misgivings about their current effectiveness. Dr Evans was concerned that *"one agency rarely taking part is Health"* and that *"decisions are taken about children …. without input from Health"*. Dr Rahman felt that this was partly because *"there is no resourcing for strategy meetings under the current financial system, which only pays for activity where the patient is present."* This prompted another participant to observe that *"Unfortunately, the Working Together 2006 Guidelines suggest only that a health professional should be consulted 'if needed', whilst paediatricians are not invited to strategy discussions or meetings, even if we have been the first examiner. Named and designated (health) professionals are there to make sure that child services… are fit for purpose. I am concerned that some independent contractors employ people who are not fit for purpose, and that as a result (of the lack of Health involvement) some Local Safeguarding Children Boards (LSCBs) are failing to deal with this."*

Picking-up Dr Evans' comment about different agency agendas, Dr Morris asked delegates "*to what extent do different agencies have different agendas? Is this a significant problem? If so, how can it be dealt with?"*

Dr Mary Pillai, a consultant gynaecologist and forensic sexual assault examiner from Cheltenham General Hospital, answered *"I think there are different agendas. We experience this most particularly with medical examination; most doctors are employed by outsourced providers. They cover the examination, but what about the rest of the process? Who talks to the doctor again between the initial examination and the court case? Sometimes a lack of pre-court liaison can make cases founder. There is difficulty in the interaction between agencies."* Questioned further by Dr Morris, Dr Pillai said she was concerned that *"where the police have outsourced medical examinations, often the outsourced provider has no further interest in close involvement in cases."* Echoing Dr Stathopulu's earlier point, Dr Pillai also commented that *"One of the biggest problems is unrealistic expectations. With child abuse, people recognise physical symptoms … However children, particularly prepubertal children, are generally not abused in a way that will leave evidence. 95% of examinations will indicate a range of normal physical activity; sometimes key evidence is based on minor anatomical variations."*

Dr Jacqui Mok also had concerns about outsourcing, saying *"We have similar difficulties in Scotland, where some police services outsource medical examinations. This situation has arisen because of the difficulties in recruitment of forensic examiners, and also because the police have been given the responsibility of running a medical / health service with little understanding of the standards required. However, there are pockets of good practice."*

Dr Evans was also concerned about disagreements between agencies as to the best way forward with a case. *"Where there is a dispute,"* she said *"there is nowhere to go for the professional; you tell your manager (but)…. no one person takes responsibility. Until we have some sort of dispute resolution mechanism in place, we will continue to have '31 missed opportunities' such as occurred in a case in Doncaster recently."*

Dr Morris sympathised but said that the task of co-ordinating the efforts of so many different agencies is a complex one. *"Where patients are often seen by 15 different specialists" he observed "it is hard to see how multiple separate agencies could coordinate things properly."*

Nigel King agreed but felt that *"the SCBs should manage those issues"* whilst other participants called for 'serious case review groups' and / or 'management review groups'. Dr Lloyd felt that where things had clearly 'gone wrong' *"we perhaps need confidential enquiries, such as there are into maternal and child deaths. They allow people to reveal what they did or did not do in a particular case without there being any blame."*

Training

The discussion turned again to the issue of training first raised by Dr Mok; more specifically the question of training in what and for whom. Professor Ian Wall, President of the Faculty of Forensic & Legal Medicine, Royal College of Physicians, made the point that *"as well as joint working, there has to be appropriate training for doctors doing this work. This is not happening in some areas; over half the country has this work outsourced to private provider companies, where perhaps all they are interested in is having the title doctor. As a faculty, we are trying to set appropriate standards, for minimum training requirements. Further, we have to get over to the judiciary that in the majority of cases there are no abnormal findings. I think the teaching aid will be a big help."*

Dr Simon Jones, designated Doctor for child abuse in North Hampshire was more concerned with the need to educate the general public, commenting that *"raising public awareness… is crucial to the identification of children who have been sexually abused. EastEnders ran a very credible story about a teenager being abused, for example. Members of the public need to be more aware of how abuse presents so we can hear children properly and pass-on information appropriately."*

Tink Palmer, CEO of the Marie Collins Foundation, observed that *"It is essential that professionals involved in Child Sexual Abuse cases who are required to give evidence have the skills to withstand the witness experience".*

Jo Delahunty QC, of Garden Court Chambers, a Barrister with a particular interest in child protection, agreed saying "*people need empowerment through training to prepare for giving evidence in court: training to support them at the outset of their involvement with a child, enabling them to appropriately elicit factual information, and then training on how to manage the court environment at the end of their dealings with the case when, as a witness, they are being challenged, or are explaining what they did and why. In care cases the court is not concerned with punishment of the alleged offender or proving guilt or innocence as in criminal cases. In family courts the child's welfare is the focus: it is a question of establishing if a child has been harmed, and if so, by whom so as to determine what action needs to be taken to protect the child from further harm. In care cases there is open disclosure of all evidence filed to all parties, including medical evidence. In this way it differs from criminal cases. You could end up giving evidence in both cases. A consistent and high standard of training for doctors, social workers, health visitors, teachers and foster carers is essential to avoid potential corruption of evidence when taking and recording information from a child. What you do with the child and what you then say to the court is invaluable. Lawyers pick up the case after the events you were involved with have taken place and we look back, with the benefit of hindsight at all the subsequent evidence in the case, to judge what you did or did not do. Your role is invaluable, at the time and in court, but we need you to be equipped to deal with challenges in court: after all, if facts weren't in dispute you wouldn't be needed at all. So be prepared".*

Dr Lucy Love, a paediatrician with Darent Valley Hospital NHS Trust in Kent said that she had been fortunate enough to have received excellent court training which *"I would like to see made compulsory for anyone expected to give evidence in court, because it can be intimidating. I would also like to see better quality training for forensic physicians. I thought that the Primary Care Trusts were going to be responsible for their training; that would hopefully mean better quality training."*

Another participant noted that *"The Royal College for Paediatrics and Child Health is taking training very seriously, defining the levels paediatricians need to work to. Court skills are included within that training, as well as looking at some of the difficulties within networks, for example whom to refer patients to afterwards. You need a very good health network to feed into a multi-agency framework."*

Initial child-disclosure

Dr Morris asked *"If it is true that 25% of referrals come from teachers, who do the other 75% tell – is it another relative, or health professionals? Who should we target for education?"*

Nigel King, representing the National Executive Committee of BASPCAN, said that when he served as a police officer in a Child Abuse Investigation Unit, he conducted research to determine whom children first told of being abused. *"The mother was the first person told, by a significant margin"* he said. "*Next was a school friend."*

Tink Palmer was particularly concerned about health professionals, commenting that *"In my role, consulting with children who have been sexually abused, children have described how wonderful it was when a doctor or nurse believed them. Health workers are considered 'safe' to tell, but many children feel prevented by a perception that a doctor is rushed, or has a demeanour that makes him/her unapproachable".*

Dr Joanne Nelson, a Consultant Paediatrician from Northern Ireland reminded the Forum that many instances of abuse simply go unreported. She said that "*for the 'SAVI Report' of 2002, in Ireland, researchers interviewed 2,000 adults about their experiences. Of those, 47% had never disclosed to anyone other than the researchers that they had been abused."* She continued *"To promote disclosure, we are responsible for creating an environment in which children feel they could tell someone."*

Jo Delahunty was keen to emphasise the role often played by foster parents, saying *"In my experience children tend to disclose, or make allegations as we term it, when they feel safe, so often not when they are at home, exposed to or living with the abuser."* She continued *"when examining the probative force of allegations, much depends on what the child has said and done in a number of different contexts. A medical examination is simply one part of the child's involvement with professionals. When conducting a physical examination of the child it's not just what physical signs you observe, but also how the child presents and what may be said to and by the child. A medical examination is a snapshot in time but it will be put in the context of everything else that is known about the child. Be reassured we, as lawyers, do not expect medical examinations to produce conclusive evidence of abuse, it rarely does. But your role goes wider than looking for the presence or absence of physical abuse. You have direct contact with the child and see him/her in the earliest stages of an investigation: what the child says and does is important information. Again, training is vital in abuse cases as inaccurate recording of what a child says, without putting it in the context of what was happening around her, risks evidentially undermining a case of abuse. Ultimately you are best served by training consistent with the ABE (Achieving Best Evidence) guidelines that the police have to apply when dealing with a child. My biggest successes in court when undermining allegations of abuse have been when questioners (teachers, foster carers etc) have specifically been 'fishing' for information and asking leading questions on the basis that they believe the child wants to say something and has been abused."*

Innovation, quality and peer review

Dr Rahman expressed concern that *"There is no quality control in child protection as there is no agreed quality indicator. The simple measure of peer review as a support for doctors is not set up in most places, and it is difficult for some colleagues even to get the time to discuss cases because, as I mentioned earlier, the current financial system only pays for activity where the patient is present."* Dr Morris found this regrettable, observing that *"I have never been to another hospital without learning something. If we could embody that in the college standards, that would be something."* Dr Mok told the Forum that *"the College of Paediatrics and Child Health is trying to define what we mean by peer review, and to standardise it. At meetings, there is always a mix of people, and often we are too polite. They come to learn from more experienced paediatricians, rather than criticising in a constructive way."*

Dr Naughton regretted that *"there are a lot of success stories but they do not hit the headlines - or get used as action learning cases."* Agreeing, Dr Morris called for more and better research *"to establish the differences between what does and does not work."*

Other Comments

Dr Sameena Shakoor, Consultant Paediatrician with West Kent PCT, was particularly concerned about the abuse of children with learning disabilities and other difficulties, pointing out that *"A lot of evidence comes in the ABE (Achieving Best Evidence) interview, so abusers know that if they target these children they are much more likely to get away with it. This is perhaps an area where someone with special expertise is needed, such as an educational psychologist or other therapist skilled in using communication aids to get the best evidence."*

Dr Sheila Paul said it was important to offer victims reassurance about the longer-term consequences of their abuse. *"Our guidance"* she explained *"is that every child suspected of having been abused needs a full forensic medical examination, which is a dual purpose examination, both to help the police investigate the suspicions/allegations and to attend to the holistic needs of the child. It is really up to us to reassure children with regard to the potential consequences of the abuse, for example being able to have children, or to give advice on STD screening, etc."* She added *"Also, really importantly, children tend to test the water when they disclose. For example, they might say they were touched over clothes at the bus stop, but will give further disclosure during the examination, perhaps of penetration. Remember that children often normalise and may not be aware that what is happening to them is abuse."*

It was left to Dr King to wind-up the discussion. On training, she said simply *"I attended the first court skills training course the Royal College did - and I recommend it."* On peer-review, she commented *"I am glad there is more peer review being introduced. It can be infrequent because of time restraints, and perhaps not critical enough, but people do learn from it and I hope it will increase nationally."* Her final thought was on recruitment. *"What is most important, perhaps, is recruiting people into paediatrics. There is a genuine concern there will not be sufficient replacement doctors to undertake this work when we move on."*

CONCLUSIONS

The Child Protection Forum was organized by NHS Innovations South East (NISE), with two aims in mind.

The first was to share - with health colleagues and with other professionals working in the field of child sexual abuse - information about an important new training and diagnostic tool; the Oxford Child Sexual Abuse Examination Skills Trainer. The Forum featured a presentation by the inventor, Dr Sue King, and her colleague, Dr Sheila Paul and the response from delegates was extremely positive and encouraging.

The second aim of the Forum was to enable NISE, on behalf of the wider NHS Innovations 'movement' to seek the advice and opinions of their multi-disciplinary expert audience about other ways in which the NHS might be encouraged to innovate in order to improve the effectiveness of our joint efforts to protect children who have been, or are at risk of being abused.

We are indebted to our delegates and, in particular to our Discussion Forum Chair, Dr James Morris, for a wide-ranging discussion that provided us with a great deal of food for thought. Our initial conclusions, following on from that discussion, are that the need for innovation and best practice examples is greatest in the following areas:

DISCLOSURE

Public information Who do children tell, when they have been abused? The Forum heard from a representative of BASPCAN about research undertaken that revealed *"The mother was the first person told, by a significant margin. Next was a school friend."* It must be extraordinarily difficult for the mother or school friend of a child who has been abused to know what to do with the information they have been given. Is there sufficient public information? What advice and support is available to a mother who wishes to report an allegation of abuse made by her child?

Schools We heard that children often tell their teacher that they have been abused; it was suggested that teachers account for 25% of all initial referrals for suspected child abuse. Do schools have the right information-sharing protocols and referral procedures in place? Are schools sufficiently 'plugged-in' to local inter-agency arrangements? Do teachers have sufficient knowledge of CSA – and the way it is 'managed'? Do they have the right listening-skills; the ability to listen without attempting to elicit information? What training is available for teachers?

THE IDENTIFICATION OF CHILD SEXUAL ABUSE

Work with very young and particularly vulnerable children Several participants talked about the practical difficulties involved in obtaining clinical / forensic evidence of child abuse, particularly in cases where the victim is a very young child. This inevitably means that the testimony of the child - and the evidence of the adults who subsequently work with that child – assumes greater importance, especially if the case leads to criminal proceedings. However, it takes great skill to obtain meaningful (and admissible) evidence from a very young child - or a particularly vulnerable one; a child with a learning disability, for example. How much do we know about 'what works' in obtaining evidence from the youngest and / or most vulnerable victims?

MULTI-AGENCY WORKING

Effective inter-agency structures Participants told us that there is a problem – at least in some areas – of paediatricians and other health professionals being 'semi-detached' from multi-agency structures (eg Strategy meetings). Many felt that the lack of health input (due usually to pressure of other work and / or a lack of resources) resulted in poorer multi-agency decision-making and a lower quality of service. Others were concerned that existing multi-agency structures often seem unable to manage the seemingly inevitable tension between responding to the needs of the child and securing the conviction of the abuser. It would be helpful to know of areas where this is not the case; where inter-agency structures appear to be working well and where all the agencies who should be are fully-engaged, since they may have lessons for the rest of us.

Outsourcing The question of outsourcing was raised several times and is clearly causing a good deal of concern. There appear to be three (related) problems; to do with

- Quality – some participants said they had first-hand experience of services delivered by 'independent' providers that are not fit for purpose, often because staff are not properly qualified and / or trained).
- Accountability – because staff are only accountable to their employer. (So, for example, medical personnel employed in outsourced services operate outside NHS governance and accountability structures.)
- Continuity – In the case of Forensic Medical Examiner services outsourced by Police Forces, there is often little ongoing contact between the doctor conducting the initial examination and those subsequently working with the child; to the potential detriment of the child's future welfare and the likelihood of a successful criminal prosecution.

In spite of these problems, there are no indications that agencies are planning to turn away from outsourcing these vitally-important services so it would be helpful to know of any area which has managed to 'design out' these potential problems; e.g by specifying quality controls, lines of accountability and ongoing case-responsibility in contracts at the procurement stage?

TRAINING

Training was a constantly recurring theme throughout the Forum – and the need is clearly considerable. Among the training needs we logged were

- Training for medical practitioners in CSA examination skills;
- Training (multi-disciplinary?) for all professionals who work with children, in the skills of listening to children;
- Training for medical and nursing staff, social workers, foster-parents and teachers in giving evidence and other court skills;

It is, of course, a simple matter to call for more training. The difficulty is in designing training that is practical, effective and affordable – and in making available where the need is greatest. It was therefore particularly helpful to hear so many examples of positive training experiences. It would be interesting to find out whether any area has attempted to develop a comprehensive, multi-agency Child Abuse training strategy.

Dr James Morris

Brought up in Cheshire, Dr Morris attended Medical School at Oriel College, Oxford and subsequently worked as a junior doctor in Oxford. He then moved to the United States, spending some fourteen years (from 1976 to 1990) in Boston, Massachusetts at the Brigham & Women's Hospital, first training in neuropathology and then on the staff. He became a US citizen in 1990.

Dr Morris returned to Oxford in 1990 to become Head of the Neuropathology Department at the Radcliffe Infirmary and Consultant Neuropathologist. He was Medical Director at the Radcliffe Infirmary from 1993 – 2000 and, since 2001, has been Medical Director of the The Oxford Radcliffe Hospitals NHS Trust which comprises the John Radcliffe Hospital (now including the Children's Hospital & West Wing Depts), Churchill Hospital and Horton Hospital. He also continues to practise neuropathology.

Following the UK General Election in May 2010, Earl Howe was appointed Parliamentary Under-Secretary of State for Quality (Lords) at the Department of Health. His wide-ranging Ministerial responsibilities include both Innovation and Research & Development.

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